STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Healthcare Center	1242 Cedars CT Charlottesville, VA 22903

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on review of facility's documentation and staff interview, it was determined that the facility failed to allow the resident to make decisions regarding her treatment for one of nine residents, Resident #2. The findings included: The facility failed to allow the resident to make decisions regarding her treatment. Resident #2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to encephalopathy, COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure) and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 12/31/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring total dependence for transfer, bathing, bed mobility, dressing, hygiene and supervision for eating. A review of the comprehensive care plan dated 2/3/22 revealed, FOCUS: Resident is at risk for nausea/vomiting and stomach pain related to Gastroenteritis/IBS (irritable bowel syndrome) and history of episodes of partial intestinal obstruction. INTERVENTIONS: Observe signs/symptoms of complication of nausea and vomiting (dehydration {hypotension, dry mucous membranes, fever, dry skin, tachycardia}, weight loss, pain, weakness and fatigue). A review of the progress note dated 11/13/23 at 7:41 AM, revealed, 11p-7a. at the beginning of the shift resident was requesting to go to the hospital secondary to stomach cramping resident received Miralax, senna & Bentyl just prior to this shift. incontinent care was provided with a large stool. resident also coughed up a large amount of clear mucous. VS: 174/80 - 98.3 - 108 - 20 - O2sats 97% with O2 via NC. resident stated that she is starting to feel better since she got that stuff out of my throat. resident decided to not go to the ER at this time. resident slept well during the rest of the night. call bell in reach & is able to make needs known. will continue to monitor. A review of the progress note dated 11/23/23 at 9:20 PM, revealed, Resident is complaining of abdominal cramping on upper part of her abdomen. Dicyclomine 10mg capsule given as needed medication. After few minutes resident called daughter and daughter came to the facility and called 911. Notify MD and made him aware and updated. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress note dated 11/23/23 at 9:40 PM, revealed, The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition. At the time of evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure: 134/67, Pulse: 83, RR: 20, Temp: T 96.2, Pulse Oximetry: O2 94.0 % - Oxygen via Nasal Cannula, Blood Glucose: 170.0. Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Does the resident/patient have pain? Yes. Nursing observations, evaluation, and recommendations are: Complaining of abdominal cramping- Dicyclomine HCl Oral Capsule 10 MG as needed medication given as per ordered. Daughter called 911. Notify MD that resident wants to go to the hospital and advised to send him to the ER for further management and evaluation. Primary Care Provider responded with the following feedback: advised to send him to the ER for further management and evaluation. On 8/15/24 at 7:00 AM an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated, yes, I remember Resident #2. She would call EMS herself, if meds were not given how and when she wanted it, or she would call her daughter. She complained about abdominal pain. She has something like IBS (irritable bowel syndrome). When asked if the resident requests to go to the ER, do they have the right to go to the ER, LPN #1 stated, yes, they have that right. We try to treat them in the meantime based on their concerns. I will contact the physician or telehealth, but if resident is adamant about going, certainly will send her to the ER. An interview was conducted on 8/16/24 at 8:00 AM with RN (registered nurse) #1. When asked if she remembered Resident #2, RN #1 stated, yes, she was an amputee, difficulty breathing, SOB, stomach. If the resident wants to go out, people know their bodies and how they feel. I do know she had been complaining about her stomach and she was hollering out in pain and she said was needing to go out, and the aide said she had called 911. It is a right for the resident to make their treatment decisions. I have heard another nurse tell a patient that if they wanted to go out, they could call 911 themselves. 8/16/24 at 8:45 AM ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director were made aware of the findings. A review of the facility's Resident Rights policy revealed, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The purpose of this policy is to guide employees in the general principles of dignity and respect of caring for residents, including the right to refuse treatment and care and the rights and safety of other residents, staff and visitors. Residents have a choice and a voice in how they will be treated. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observation, resident/staff interview, facility document review, and clinical record review, the facility staff failed to report an allegation of resident who was on the roof with potential for self-harm for 1 of 9 residents, Resident #3. The findings include: The facility failed to report an allegation that a resident was on the roof with potential for self-harm, Resident #3. Resident #3 was admitted to the facility on [DATE] with diagnosis that included but were not limited to trach, hypertension and psychoactive substance abuse. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 6/27/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating Resident #3 was cognitively intact. A review of the MDS Section GG-functional abilities and goals coded Resident #3 (R3) as being independent for walking/bathing/transfer/dressing/toileting, and eating. A review of R3 comprehensive care plan with a revision date of 1/5/23, revealed, FOCUS: Resident is noted with impulsive behaviors related to loss of independence, ADHD, attempting to exit from unauthorized doors on unit, attempting to climb out of facility window. INTERVENTIONS: Behavioral health consults as needed. Monitor behavioral episodes and attempt to determine underlying causes. Notify medical provider of increased episodes of behaviors. A review of the facility event synopsis dated 3/14/24 revealed, The resident climbed out of the window of the wing 2 hallway. He has a BIMS score of 14. The unit 2 window was fixed immediately. Resident had an immediate psych eval. The psych physician recommended the resident be sent to the ED for eval. However, EMS refused to take the resident as he refused to go to the ED. EMS stated he is in his right mind. A skin assessment was completed. The resident stated he was fine. One to one staffing initiated. 100% of all other windows were completed and functional safety in place. The fax confirmation documented that this synopsis was faxed to the VDH-OLC (Virginia Department of Health-Office Licensure Certification) on 3/14/24 at 3:31 PM. R3's progress note dated 3/10/24 at 8:03 PM revealed, At 5:00 PM this writer was alerted to 3 staff members saying my name and then saying resident was climbing out of window. This writer who was passing medications asked staff to please get him out and away from the window. Resident ends up on the floor with a small abrasion above his left eyebrow. Neuro checks started and WNL's (within normal limits). Physician and DON (director of nursing) notified. Resident is his own RP (responsible party). Will continue Neuro checks. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R3's psych NP (nurse practitioner) progress note dated 3/12/24 at 1:00 AM, revealed, Chief Complaint /Nature of Presenting Problem: Suicidal ideation with plan. Patient is a [AGE] year-old male with past psychiatric history of attention-deficit hyperactive disorder and major depressive disorder. Since last encounter, there have been no changes to psychotropic medications. Per staff reports, patient jumped off the roof last week. Today, staff reports that patient tried jumping again from the roof but this time his pants leg got caught on something and he hit his head on the way down. I was able to speak with him today and he states that, Next time he will walk out in traffic. He has been made aware that he cannot remain in the facility, as his behavior is very unsafe. He agrees to go to the hospital for further psych evaluation and states, Well, I will have a roof over my head and 3 meals. Recommendations: Patient is being treated for depression. He is suicidal with a plan. RECOMMENDATION: Send to ED for further psychiatric evaluation. A review of R3's progress note written 3/12/24 at 4:57 PM revealed, Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis) Other change in condition. Behavioral Status Evaluation: Danger to self or others Suicide potential. Other behavioral symptoms. Nursing observations, evaluation, and recommendations are Resident told Psych NP that he had a plan to attempt to comminute suicide. Stated he was going to walk in front of bus out front. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: send for PYSCH EVAL. A review of R3's progress note written 3/12/24 at 5:43 PM revealed, Officer came out to assess patient. Resident stated he was fine. They said only way they can take him is to obtain ECO (emergency custody order). Resident is in room resting will continue to monitor. Physician and Psych NP made aware. An interview was conducted on 8/14/24 at 3:45 PM with R3. When asked to describe the incident on the roof, R3 stated, It was nothing and I have not gone back on the roof since March. An interview was conducted on 3/15/24 at approximately 12:00 PM with ASM #1, the executive director. When asked if this was the complete facility event synopsis folder for Resident #3's roof incident, ASM #1 stated, Yes, that is the copy of the entire folder. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director were made aware of these findings. A review of the facility's Occurrence Reporting policy revealed, The administrator is responsible for the oversight of timely reporting to Federal, State, and Local authorities as appropriate. The facility provided their enacted a plan of correction, which contained the following 5 points: STEP 1: On 3/10/24, Resident (Resident #3) got out of the window and had a fall attempting to get back into the building through the window. 1. Resident was assessed for injuries related to fall on 3-10-24. 2. Neuro checks initiated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Change in condition completed 4. UDA triggers, fall follow up and post fall assessment completed. 5. Nursing to therapy referral done. 6. MD/DON/Self/RP notified. 7. PTSD screen done. 8. Pain assessment done. 9. Head count done. 10. Resident was seen by psychiatric nurse practitioner on 3/13/24. 11. Resident's care plan was updated for mood and behavior on 3/16/24. 12. Resident's behavior management plan will be initiated by 3/18/24 and will be reviewed weekly to ensure progress is made on a continual basis. 13. Resident was educated on 3/15/24 by the ED on resident appropriate areas and safety. 14. Resident placed on 1 to 1 monitoring on 3/12/24. 15. Statements obtained from resident and staff. 16. Pharmacy medication review on 3/18/24. 17. Social Services assessment and follow up for psychosocial impact and support. STEP 2: 1.Resident #3 and like residents with potential similar risks were identified and reviewed with care plans updated. 2. Window to roof top secured immediately and lock mechanism placed on 3-12-24. 3. Audit of all facility windows checked for lock mechanism and secured, completed on 3-15-24. See floor diagram. 4. ED/DON/ADON conducted in-service training for all staff to be completed by 3-18-24. Training included reporting of maintenance and repair issues in the work order system (TELS). 5. Staff education on timely clinical investigation and documentation. 6. Staff to be educated on risk protocol reporting. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Review risk escalation policy with ED and DON. STEP 3: 1. The facility maintenance director or designee will perform weekly audits of facility windows to ensure lock mechanism in place for the next 4 weeks, monthly for the next quarter and then quarterly. 2.ED to hold a resident meeting on 3-18-24 to discuss safety concerns and unauthorized areas. STEP 4: 1.IDT QAPI team will review the abatement plan during QAPI on 3-18-24. The plan will then be updated as needed to include any new interventions that have been identified. Plan will be reviewed monthly for the next two quarters. STEP 5: Completion date 3-18-24 The credible evidence supporting the Plan of Correction, including observation of windows accessing the roof top, education, in-service sign in sheets, audits, and Quality Council minutes, was reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding abuse education and training and failed to reveal any concerns. Review of current residents failed to identify any concerns. Therefore, the above deficient practice was cited as Past Noncompliance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for one of nine residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to implement the resident's comprehensive care plan for pressure injury treatments. R4's comprehensive care plan dated 9/6/23 documented, Resident with potential impaired skin integrity or actual impaired skin integrity r/t (related to) pressure ulcer to right heel .Treatments as ordered .Left Achillies wound on admission 3/05/24 .TX (Treatment) as ordered . A review of R4's clinical record revealed the following physician's orders: 2/27/24-cleanse the stage three right heel wound with wound cleanser. Apply silvasorb gel to the wound bed and cover with gauze, ABD (wound dressing), and rolled gauze daily. 3/5/24-cleanse the left Achillies wound with wound cleanser, apply silvasorb, abd, kerlix every day. A wound physician note dated 5/7/24 documented a stage three right heel pressure injury measuring 1.9 cm (centimeters) (length) x 2.2 cm (width) x 0.5 cm (depth), with 75-99% slough (dead skin tissue) and a stage four left Achilles pressure injury measuring 1.5 cm x 2.3 cm x 0.4 cm with 75-99% slough. A review of R4's May 2024 TAR (treatment administration record) revealed the same physician's orders. Further review of R4's May 2024 TAR failed to reveal treatments were administered for both pressure injuries on 5/11/24, 5/16/24, 5/18/24, and 5/26/24 (as evidenced by blank spaces on the TAR). Nurses' notes for those dates failed to reveal documentation that the treatments were done. On 8/15/24 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the care plan, specifies what's going on with that patient and make it ideal to them as best as we capture their stuff. LPN #3 stated the care plan individualizes care for residents. LPN #3 stated nurses can pull up residents' care plans and read them to make sure they are implementing them. LPN #3 stated pressure injury treatments display on the TAR and the nurses evidence the treatments are done by signing off on the TAR. On 8/16/24 at 8:43 A.M., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled, Plan of Care Overview documented, PoC: for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care. No further information was presented prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide incontinence care for dependent residents for three of nine residents, Resident #3, Resident #6 and #7. The findings include: 1.The facility staff failed to provide evidence of incontinence care for dependent Resident #3. Resident #3 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), COPD (chronic obstructive pulmonary disease), congestive heart failure and encephalopathy. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 12/31/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 2/29/22, revealed, FOCUS: Resident is incontinent of urine due to impaired mobility, Max-Dependent with ADL (activities of daily living) assist for toileting. INTERVENTIONS: Check resident for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Apply barrier creams as needed. A review of the December 2023 ADL (activities of daily living) record revealed missing documentation for following shifts and dates: Day: 12/2, 12/9, 12/29; Evening: 12/29, 12/30, 12/31 and Night: 12/2, 12/7, 12/27, 12/28, 12/29 and 12/31. A review of the January 2024 ADL record revealed missing documentation for following shifts and dates: Day: 1/1; Evening: 1/5, 1/8 and Night: 1/2, 1/3 and 1/9. On 8/14/24 at 12:35 PM an interview was conducted with CNA (certified nursing assistant) #1. When asked the process for incontinence care, CNA #1 stated, we round every two hours and provide the incontinence, turning/repositioning at those times. When asked where the incontinence care would be evidenced, CNA #1 stated, we document on our tablets into PCC (point click care). On 8/16/24 at 8:25 AM an interview was conducted with CNA #2. When asked the process for incontinence care, CNA #2 stated, we provide incontinence care every two hours, we start rounds when we come on shift. When asked where this would be documented, CNA #2 stated, in the ADL form in PCC. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director was made aware of the concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Routine Resident Care policy revealed Provide routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to: Toileting, providing care for incontinence with dignity and maintaining skin integrity. No further information was provided prior to exit. 2.The facility staff failed to provide evidence of incontinence care for dependent Resident #6. Resident #6 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease), DM (diabetes mellitus), Mitral valve stenosis and post kidney transplant. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/15/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 3/25/24, revealed, FOCUS: Resident is incontinent of urine and requires assistance with toileting hygiene. INTERVENTIONS: Check resident for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Apply barrier creams as needed. A review of the June ADL (activities of daily living) record revealed missing documentation for following shifts and dates: Day: 6/1, 6/2, 6/3, 6/10, 6/16, 6/25; Evening: 6/12, 6/16, 6/29, 6/30 and Night: 6/1, 6/4, 6/14, 6/17, 6/24 and 6/30. A review of the July ADL record revealed missing documentation for following shifts and dates: Day: 7/6, 7/17 and Night: 7/1, 7/5, 7/16, 7/21 and 7/24. On 8/14/24 at 10:25 AM an interview was conducted with Resident #6. When asked about incontinence care being provided, Resident #6 stated, they are usually pretty good. Sometimes there is waiting. On 8/14/24 at 12:35 PM an interview was conducted with CNA (certified nursing assistant) #1. When asked the process for incontinence care, CNA #1 stated, we round every two hours and provide the incontinence, turning/repositioning at those times. When asked where the incontinence care would be evidenced, CNA #1 stated, we document on our tablets into PCC (point click care). On 8/16/24 at 8:25 AM an interview was conducted with CNA #2. When asked the process for incontinence care, CNA #2 stated, we provide incontinence care every two hours, we start rounds when we come on shift. When asked where this would be documented, CNA #2 stated, in the ADL form in PCC. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director was made aware of the concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Routine Resident Care policy revealed Provide routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to: Toileting, providing care for incontinence with dignity and maintaining skin integrity. No further information was provided prior to exit. 3. The facility staff failed to provide evidence of incontinence care for dependent Resident #7. Resident #7 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CVA (cerebrovascular accident), aphasia, hemiparesis/hemiplegia and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 7/15/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 10/26/23, revealed, FOCUS: Resident is incontinent of urine and requires assistance with toileting hygiene. INTERVENTIONS: Check resident for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Apply barrier creams as needed. A review of the June ADL (activities of daily living) record revealed missing documentation for following shifts and dates: Day: 6/1, 6/2, 6/29; Evening: 6/11 and Night: 6/1, 6/4, 6/7, 6/23, 6/24 and 6/30. A review of the July ADL record revealed missing documentation for following shifts and dates: Night: 7/9, 7/16, 7/29 and 7/31. A review of the August ADL record revealed missing documentation on night shift 8/11. On 8/14/24 at 11:25 AM an interview was conducted with Resident #7. When asked about incontinence care being provided, Resident #7 stated, it is okay. When asked do they come when she calls, Resident #7 stated, yes. On 8/14/24 at 12:35 PM an interview was conducted with CNA (certified nursing assistant) #1. When asked the process for incontinence care, CNA #1 stated, we round every two hours and provide the incontinence, turning/repositioning at those times. When asked where the incontinence care would be evidenced, CNA #1 stated, we document on our tablets into PCC (point click care). On 8/16/24 at 8:25 AM an interview was conducted with CNA #2. When asked the process for incontinence care, CNA #2 stated, we provide incontinence care every two hours, we start rounds when we come on shift. When asked where this would be documented, CNA #2 stated, in the ADL form in PCC. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director was made aware of the concerns. (continued on next page)

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Cedars Healthcare Center	1242 Cedars CT Charlottesville, VA 22903

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to maintain residents' highest level of well-being for two of nine residents in the survey sample, Residents #4 and #5. The findings include: 1. For Resident #4 (R4), the facility staff failed to provide physician ordered treatments for the resident's arterial wound on multiple dates in May 2024. A review of R4's clinical record revealed a physician's order dated 4/23/24 to cleanse the arterial left lateral heel with wound cleanser, apply silvasorb, gauze, abd pad (wound dressing), kerlix and ace wrap every day. A wound physician note dated 5/7/24 documented the wound as an arterial left lateral heel wound measuring 1.2 cm (centimeters) (length) x 1 cm (width) x 0.1 cm (depth). A review of R4's May 2024 TAR (treatment administration record) revealed the same physician's order. Further review of R4's May 2024 TAR failed to reveal treatment was administered on 5/11/24, 5/16/24, 5/18/24, and 5/26/24 (as evidenced by blank spaces on the TAR). Nurses' notes for those dates failed to reveal documentation that the treatments were done. On 8/15/24 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated wound treatments display on the TAR and the nurses evidence the treatments are done by signing off on the TAR. On 8/16/24 at 8:43 A.M., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Wound Care documented, Residents/patients admitted with or develop skin integrity issues will receive treatment as indicated based on location, stage and drainage. No further information was presented prior to exit. 2. For Resident #5 (R5), the facility staff failed to measure and record nephrostomy tube (1) output per a physician's order on multiple dates in July 2024 and August 2024. A review of R5's clinical record revealed a physician's order with a start date of 7/24/24 that documented, Nephrostomy Tube measure and record output every shift. A review of R5's July 2024 and August 2024 TARs (treatment administration records) revealed the same physician's order. Further review of R5's July 2024 and August 2024 TARs failed to reveal the resident's nephrostomy tube output was monitored and recorded on 7/26/24 during the night shift, 7/28/24 during the evening shift, 7/31/24 during the night shift, 8/8/24 during the evening shift, 8/9/24 during the day shift, and 8/9/24 during the evening shift (as evidenced by blank spaces on the TAR). Nurses' notes for those dates failed to reveal documentation that the nephrostomy tube output was monitored and recorded on those dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/15/24 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of monitoring and recording nephrostomy tube output is to see how much urine is coming out. LPN #3 stated nurses should document output on the TAR. On 8/16/24 at 8:43 A.M., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not have a specific policy regarding the monitoring and recording of nephrostomy tube output. No further information was presented prior to exit. Reference: (1) A percutaneous nephrostomy is the placement of a small, flexible tube (catheter) through your skin into your kidney to drain your urine. It is inserted through your back or flank. This information was obtained from the website: https://medlineplus.gov/ency/article/007375.htm

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for the treatment of pressure injuries for one of nine residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to provide physician ordered treatments for the resident's stage three right heel pressure injury (1) and stage four left Achillies pressure injury (1) on multiple dates in May 2024. A review of R4's clinical record revealed the following physician's orders: 2/27/24-cleanse the stage three right heel wound with wound cleanser. Apply silvasorb gel to the wound bed and cover with gauze, ABD (wound dressing), and rolled gauze daily. 3/5/24-cleanse the left Achillies wound with wound cleanser, apply silvasorb, abd, kerlix every day. A wound physician note dated 5/7/24 documented a stage three right heel pressure injury measuring 1.9 cm (centimeters) (length) x 2.2 cm (width) x 0.5 cm (depth), with 75-99% slough (dead skin tissue) and a stage four left Achilles pressure injury measuring 1.5 cm x 2.3 cm x 0.4 cm with 75-99% slough. A review of R4's May 2024 TAR (treatment administration record) revealed the same physician's orders. Further review of R4's May 2024 TAR failed to reveal treatments were administered for both pressure injuries on 5/11/24, 5/16/24, 5/18/24, and 5/26/24 (as evidenced by blank spaces on the TAR). Nurses' notes for those dates failed to reveal documentation that the treatments were done. On 8/15/24 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated pressure injury treatments display on the TAR and the nurses evidence the treatments are done by signing off on the TAR. On 8/16/24 at 8:43 A.M., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Slough Treatment documented, 6. Implement treatment as ordered. No further information was presented prior to exit. Reference: (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a safe environment by monitoring the wander guard for one of nine residents, Residents #9. The findings include: During the abbreviated complaint survey 8/14/24 through 8/16/24 review of the facility event synopsis, the elopement of Resident #9 on 6/30/24 was reviewed. Resident #9 was admitted to the facility on [DATE] with diagnosis that included but were not limited to dementia, hypertension and macular degeneration. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/6/24, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and supervision for eating. A review of the comprehensive care plan dated 4/30/24 revealed, FOCUS: Resident is an elopement risk. INTERVENTIONS: Apply secured device. Check placement every shift, check function and door transmitter daily. Document in the order the expiration date of the secured device. Notify staff of elopement risk. A review of the physician orders dated 4/30/24 revealed, Wander bracelet placed on Left ankle. Check placement every shift, and properly functioning daily. A review of the May/June/August TAR (treatment administration record) revealed missing wander guard functioning day shift documentation on the following dates: 5/3, 5/10, 5/30, 6/2, 6/7, 6/8, 6/10, 6/11, 6/18, 6/21, 6/28, and 8/7. A review of the May/June/July TAR revealed missing wander guard placement every shift documentation on the following shifts and dates: day shift: 5/3, 5/10, 5/30, 6/2, 6/7, 6/8, 6/10, 6/11, 6/18, 6/21, 6/28, 8/7; evening shift: 6/1, 6/2, 6/10, 6/11, 6/18, 6/21, 6/28 and night shift: 5/10, 5/17, 6/7, 6/8, 6/13, 7/4 and 7/16. A review of the progress note dated 6/30/24 at 1:45 PM revealed, Resident psychotropic medication was reviewed with pharmacy and IDT (interdisciplinary team). Target behaviors for resident include yelling, hitting, cussing, and scratching. Recommendation is for GDR (gradual dose reduction) of Quetiapine 50 MG in the morning to 12.5 mg two times a day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the progress note dated 6/30/24 at 5:00 PM revealed, At 1:00PM resident was observed outside building in parking lot by social worker. Resident assisted back in building. Resident was upset that staff brought her inside and refused vital sign check and skin check. Offered to take resident outside in courtyard, resident also refused. Wander guard by nurse again and was functioning properly. Physician aware no new orders. POA (power of attorney) aware. An interview was conducted on 8/15/24 at 2:30 PM with LPN (licensed practical nurse) #3. When asked about the purpose of the wander guard LPN #3 stated, we first do an elopement assessment which determines if they need a wander guard. The wander guard will trigger an alarm if the resident gets too close to the exit doors. We check it for functioning daily and placement every shift. When asked where evidence of checking for function and placement would be found, LPN #3 stated, we document it on the TAR either daily or each shift. An interview was conducted on 8/16/24 at 8:25 AM with CNA (certified nursing assistant) #2. When asked what role they have in monitoring residents with a wander guard, CNA #2 stated, we check that it is present during bathing and during the day. The nurse checks also and documents the presence. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director was made aware of the concerns. A review of the facility's Wander Guard policy revealed Wander Guard or Wanderer Bracelet: A device made of durable, comfortable, waterproof plastic or silicone that has technology embedded in the form of a signal transmitter for the purpose of monitoring a resident's movement away from a safe area. TAR: Treatment Administration Record - documentation record for recording treatments that are being administered to the resident. Placement will be monitored each shift and documented on the TAR. Check for proper functioning of the bracelet daily utilizing the function tester and document on the TAR. No further information was provided prior to exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment and services for one of nine resident's indwelling catheter, Residents #1. The findings include: The facility staff failed to provide treatment and services for Resident #1's indwelling catheter. Resident #1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to toxic encephalopathy, obstructive/reflux uropathy and neuromuscular dysfunction of the bladder. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 6/16/24, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 1/8/19 revealed, FOCUS: Resident has Obstructive uropathy and neurogenic bladder and uses a foley catheter. INTERVENTIONS: Monitor and document intake and output as per facility policy. Foley catheter care as needed and daily. A review of the physician orders dated 6/17/24 revealed, : Indwelling Urinary (Foley) Catheter: measure and record output every shift. A review of Resident #1's June TAR (treatment administration record) revealed missing documentation for foley care on 6/20 day/night shift and on 6/22 day/evening shift. Missing output documentation on following shifts and dates: day shift: 6/20, 6/22, 6/23; evening shift 6/21, 6/22, 6/29 and night shift 6/20 and 6/30. An interview was conducted on 8/15/24 at 2:30 PM with LPN (licensed practical nurse) #3. When asked about resident's foley catheter care, LPN #3 stated, we do it every shift. When asked where the care would be evidenced, LPN #3 stated, we document it on the TAR. When asked about output documentation, LPN #3 stated, we document it on the TAR based on the physician orders. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director was made aware of the concerns. A review of the facility's Catheter Care policy revealed, Catheter Care at the bedside is performed to promote cleanliness and dignity and is performed by the nursing staff twice daily for residents who have an indwelling catheter. No further information provided prior to exit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a safe environment for one of nine residents, Resident #3. The findings include: The facility staff failed to ensure a safe environment for Resident #3. According to the clinical record, Resident #3 (R3) was admitted to the facility on [DATE] with diagnosis that included, but were not limited to, trach, hypertension, and psychoactive substance abuse. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 6/27/24, coded R3 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating intact cognition. A review of the MDS (minimum data set) Section GG-functional abilities and goals coded R3 as being independent for walking/bathing/transfer/dressing/toileting, and eating. A review of R3's comprehensive care plan with a revision date of 1/5/23, revealed, FOCUS: Resident is noted with impulsive behaviors related to loss of independence, ADHD, attempting to exit from unauthorized doors on unit, attempting to climb out of facility window. INTERVENTIONS: Behavioral health consults as needed. Monitor behavioral episodes and attempt to determine underlying causes. Notify medical provider of increased episodes of behaviors. A review of the facility event synopsis dated 3/14/24 reveals, The resident climbed out of the window of the wing 2 hallway. He has a BIMS score of 14. The unit 2 window was fixed immediately. Resident had an immediate psych eval. The psych physician recommended the resident be sent to the ED for eval. However, EMS refused to take the resident as he refused to go to the ED. EMS stated he is in his right mind. A skin assessment was completed. The resident stated he was fine. One to one staffing initiated. 100% of all other windows were completed and functional safety in place. The fax confirmation documented that this synopsis was faxed to the VDH-OLC (Virginia Department of Health-Office Licensure Certification) on 3/14/24 at 3:31 PM. A review of the facility corrective action plan following the 3/12/24 incident with Resident #3 on the roof, revealed, What immediate actions were taken to identify all potentially affected: like residents with potential similar risks identified and reviewed with care plan updated, window to roof top secured immediately and lock mechanism placed 3//12/24, audit of all facility windows checked for lock mechanism and secured, completed on 3/15/24, education of all staff to include reporting of maintenance and repair issues in the work order system and timely clinical investigation /documentation. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R3's progress note dated 3/10/24 at 8:03 PM revealed, At 5:00 PM this writer was alerted to 3 staff members saying my name and then saying resident was climbing out of window. This writer who was passing medications asked staff to please get him out and away from the window. Resident ends up on the floor with a small abrasion above his left eyebrow. Neuro checks started and WNL's (within normal limits). Physician and DON (director of nursing) notified. Resident is his own RP (responsible party). Will continue Neuro checks. A review of R3's psych NP (nurse practitioner) progress note dated 3/12/24 at 1:00 AM, revealed, Chief Complaint / Nature of Presenting Problem: Suicidal ideation with plan. Patient is a [AGE] year-old male with past psychiatric history of attention-deficit hyperactive disorder and major depressive disorder. Since last encounter, there have been no changes to psychotropic medications. Per staff reports, patient jumped off the roof last week. Today, staff reports that patient tried jumping again from the roof but this time is pants leg got caught on something and he hit his head on the way down. I was able to speak with him today and he states that, Next time he will walk out in traffic. He has been made aware that he cannot remain in the facility as his behavior is very unsafe. He agrees to go to the hospital for further psych evaluation and states, Well, I will have a roof over my head and 3 meals. Recommendations: Patient is being treated for depression. He is suicidal with a plan. RECOMMENDATION: Send to ED for further psychiatric evaluation. A review of R3's progress note written 3/12/24 at 4:57 PM revealed, Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis) Other change in condition. Behavioral Status Evaluation: Danger to self or others Suicide potential. Other behavioral symptoms. Nursing observations, evaluation, and recommendations are Resident told Psych NP that he had a plan to attempt to comminute suicide. Stated he was going to walk in front of bus out front. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: send for PYSCH EVAL. A review of R3's progress note written 3/12/24 at 5:43 PM revealed, Officer came out to assess patient. Resident stated he was fine. They said only way they can take him is to obtain ECO (emergency custody order). Resident is in room resting will continue to monitor. Physician and Psych NP made aware. An interview was conducted on 8/14/24 at 3:45 PM with Resident #3. When asked to describe the incident on the roof, Resident #3 stated, It was nothing and I have not gone back on the roof since March. An interview was conducted on 8/15/24 at 8:13 AM with OSM (other staff member) #5, the maintenance director. When asked to describe the notification process regarding the window on Unit 2, OSM #5 stated, The work ticket was in TELS, that the window had been damaged. I went up to repair the window. The stops had been broken off of the window. After I repaired the window, an employee told me a resident had gone out on the roof. When it happened, I spoke with the Fire Marshall about what I could do. The Fire Marshall reviewed fire evacuation plan and fire drill and said there was more danger on the roof top; so, screws could go in frame or brackets to keep the window from being raised. No further instances of resident trying to climb out onto the roof. On 8/16/24 at 8:45 AM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the interim executive director was made aware of these findings. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Elopement Prevention and Management Overview policy revealed, Unsafe wandering is defined as when a resident/patient enters an area that is physically hazardous or contains potential safety hazards. Check all exit doors and windows are secure. The facility provided their enacted plan of correction, which contained the following 5 points: STEP 1: On 3/10/24, Resident (Resident #3) got out of the window and had a fall attempting to get back into the building through the window. 1. Resident was assessed for injuries related to fall on 3-10-24. 2. Neuro checks initiated. 3. Change in condition completed 4. UDA triggers, fall follow up and post fall assessment completed. 5. Nursing to therapy referral done. 6. MD/DON/Self/RP notified. 7. PTSD screen done. 8. Pain assessment done. 9. Head count done. 10. Resident was seen by psychiatric nurse practitioner on 3/13/24. 11. Resident's care plan was updated for mood and behavior on 3/16/24. 12. Resident's behavior management plan will be initiated by 3/18/24 and will be reviewed weekly to ensure progress is made on a continual basis. 13. Resident was educated on 3/15/24 by the ED on resident appropriate areas and safety. 14. Resident placed on 1 to 1 monitoring on 3/12/24. 15. Statements obtained from resident and staff. 16. Pharmacy medication review on 3/18/24. 17. Social Services assessment and follow up for psychosocial impact and support. STEP 2: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Healthcare Center	1242 Cedars CT Charlottesville, VA 22903

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Resident #3 and like residents with potential similar risks were identified and reviewed with care plans updated. 2. Window to roof top secured immediately and lock mechanism placed on 3-12-24. 3. Audit of all facility windows checked for lock mechanism and secured, completed on 3-15-24. See floor diagram. 4. ED/DON/ADON conducted in-service training for all staff to be completed by 3-18-24. Training included reporting of maintenance and repair issues in the work order system (TELS). 5. Staff education on timely clinical investigation and documentation. 6. Staff to be educated on risk protocol reporting. 7. Review risk escalation policy with ED and DON. STEP 3: 1. The facility maintenance director or designee will perform weekly audits of facility windows to ensure lock mechanism in place for the next 4 weeks, monthly for the next quarter and then quarterly. 2.ED to hold a resident meeting on 3-18-24 to discuss safety concerns and unauthorized areas. STEP 4: 1.IDT QAPI team will review the abatement plan during QAPI on 3-18-24. The plan will then be updated as needed to include any new interventions that have been identified. Plan will be reviewed monthly for the next two quarters. STEP 5: Completion date 3-18-24 The credible evidence supporting the Plan of Correction, including observation of windows accessing the roof top, education, in-service sign in sheets, audits, and Quality Council minutes, was reviewed and found to be in order. Random interviews were conducted with staff on varying shifts regarding abuse education and training and failed to reveal any concerns. Review of current residents failed to identify any concerns. Therefore, the above deficient practice was cited as Past Noncompliance.